

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 4-7-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, joint mobilization, manual traction, myofascial release, physical performance test, muscle testing, and range of motion measurements for dates of service 4-22-03 through 7-3-03 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 7-2-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT Codes 99213, 97110 and 95851 for dates of service 7-7-03 and 7-11-03 were denied by the carrier with "E" denial codes. However, there was no TWCC 21 filed with the Commission. In its position letter the insurance carrier stated that no reconsideration HCFA's were submitted. However, the requestor has submitted two sets of EOB's – the initial set contained E denials for these dates of service. The second set contained O denials. Therefore recommend reimbursement according to the 96 Medical Fee Guideline as follows.

- Regarding CPT Code 99213 for date of service 7-7-03 and 7-11-03: **recommend reimbursement of \$96.00.**
- Regarding CPT Code 97110 for date of service 7-7-03 and 7-11-03: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Additional reimbursement not recommended.**
- Regarding CPT Code 95851 for date of service 7-11-03: **recommend reimbursement of \$36.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 7-7-03 through 7-11-03 in this dispute.

The above Findings, Decision and Order are hereby issued this 15<sup>th</sup> day of October 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** June 1, 2004

**RE:**

**MDR Tracking #:** M5-04-2469-01

**IRO Certificate #:** 5242

\_\_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### **Clinical History**

I have had the opportunity to review the medical records in the above-mentioned case for the purpose of an Independent Review. The claimant is a 23-year-old male who injured his low back on \_\_\_ making heavy skids for a temporary company. The claimant was initially seen at \_\_\_\_\_ where he was examined and given prescription medication for pain and inflammation. The claimant initial sought care at \_\_\_\_\_ on 3/19/03 from \_\_\_\_\_ whose treatment consisted of chiropractic manipulation with various physiotherapy modalities and active therapeutic exercises. The claimant had a MRI of the

lumbar spine performed on 3/20/03 from \_\_\_\_\_ which revealed a normal MRI of the lumbar spine. The claimant had nerve conduction studies of the lower extremities on 4/10/03 from \_\_\_\_\_ which were normal. The claimant has also sought care from \_\_\_\_\_ for medication management. The claimant also had peripheral nerve injections performed by \_\_\_\_\_ on 5/12/03. The claimant was released from active care on 10/13/03.

### **Requested Service(s)**

Office visits, Therapeutic Exercises, Joint Mobilization, Manual Traction, Myofascial Release, Physical Performance Test, Muscle Testing, and Range of Motion Measurements for dates of service 4/22/03-7/3/03.

### **Decision**

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

### **Rationale/Basis for Decision**

The claimant apparently suffered a soft tissue injury to the lumbar spine as a result of the injury which would allow up to 18 chiropractic visits, which includes therapeutic exercises, joint mobilization, manual traction and myofascial release over and 6-8 week period from the onset of the injury. The dates at issue were well beyond the expected healing period of a soft tissue injury and after lumbar MRI and electrodiagnostic studies were found to be normal. I form this decision by the negative MRI report of the lumbar spine, which was obtained on 3/20/03 and the Official Disability Guidelines 8th Edition. I fail to find any clinical evidence within the provided records which would support this muscle testing or range of motion studies in the lumbar spine for an apparent soft tissue injury.